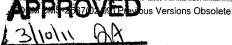
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 B. WING 155275 02/15/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1020 WEST VINE STREET** WATERS OF PRINCETON, THE PRINCETON, IN 47670 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **TAG** DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/15/11 RECEIVED Facility Number: 000175 Provider Number: 155275 AIM Number: 100274440 MAR - 7 2011 Surveyor: Lex Brashear, Life Safety Code Specialist LONG TERM CARE DIVISION At this Life Safety Code survey, The Waters of INDIANA STATE DEPARTMENT OF HEALTH Princeton was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483,70(a). Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101. Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 95 and had a census of 62 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/17/11. The facility was found not in compliance with the aforementioned regulatory requirements as LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
		155275	B. WII	NG		02/	15/2011
NAME OF F	PROVIDER OR SUPPLIER		,		ET ADDRESS, CITY, STATE, ZIP COD		
WATERS	S OF PRINCETON, TH	E	,	ľ	0 WEST VINE STREET INCETON, IN 47670		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000 K 021 SS=F	evidenced by the for NFPA 101 LIFE SA Any door in an exit enclosure, horizont hazardous area end devices arranged to doors by zone or thactivation of: a) the required man b) local smoke detection sy smoke detection sy c) the automatic spring the smoke passing through the smoke passing through the smoke detection sy the automatic spring the smoke detection sy the automatic spring the smoke detection of the smo	passageway, stairway al exit, smoke barrier or closure is held open only by a automatically close all such roughout the facility upon aual fire alarm system; actors designed to detect bugh the opening or a required stem; and rinkler system, if installed. 2 s not met as evidenced by: on and interview, the facility at the fire alarm system is s of smoke barrier doors and 1 arrier door would remain self alarm system is returned to This deficient practice could		000	Preparation and/or explan of correction in ganot constitute an adminagreement by this facinalleged or conclusions statement of deficienci correction and specific actions are prepared a in compliance with stallaws. K021 It is the intent of this the smoke barrier doccloses upon activation. I. Actions taken for identified: #1. There were no spudentified on the Effected.	eneral, or to rticular, do ssion or lity of the fast forth in es. The plate corrective nd/or execute and fede facility to enor automatical.	his pes acts this an of uted ral asure ally
	during a tour with th seven sets of smoke	on on 02/15/11 at 12:15 p.m. e Maintenance Supervisor, all e barrier doors and one single			II. How other residents#2. No other residents		ied

smoke barrier door released initially with the fire

As being effected.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		· -	(X3) DATE SURVEY COMPLETED	
	155275		B. WING			02/15/2011	
NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE				10	EET ADDRESS, CITY, STATE, ZIP CODE 120 WEST VINE STREET RINCETON, IN 47670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)		
K 021	Continued From page 2 alarm system activation, but when the system was placed in silence mode and the doors were opened, the magnetic hold devices engaged causing the smoke/fire doors to remain open instead of self closing as required. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			021	#3. Liscensed contractor All sets of fire doors Released untill the fir System is totally rese Set standards.	has repaired to remain re alarm	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.		#4. Maintenance Supervisor/Designee Will check all sets of doors for Proper operation monthly as part Of the monthly fire drill program And results will be reviewed at The quarterly QA meetings			or/Designee loors for thly as part ll program iewed at	
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations		V. Date of completion: This plan of correction constitutes ou credible allegation of compliance with all regulatory requirements. Our date compliance is 2-21-2011			npliance with ts. Our date of	

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(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 B. WING 155275 02/15/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1020 WEST VINE STREET WATERS OF PRINCETON, THE PRINCETON, IN 47670 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Preparation and/or execution of this K 144 Continued From page 3 K 144 plan of correction in general, or this where the probability of interruption of off site fuel supplies is high (e.g., due to earthquake, flood corrective action in particular, does damage or demonstrated utility unreliability), on not constitute an admission or site storage of an alternate energy source agreement by this facility of the facts sufficient to allow full output of the emergency alleged or conclusions set forth in this power supply system (EPSS) to be delivered for the class specified shall be required, with statement of deficiencies. The plan of provision for automatic transfer from the primary correction and specific corrective energy source to the alternate energy source. actions are prepared and/or executed CMS requires evidence of reliability of the natural in compliance with state and federal fuel source must contain all of the following: laws. a. A statement of reasonable reliability of the natural gas delivery; K144 b. A brief description the supports the statement It is the intent of this facility regarding the reliability; To ensure that the facility has c. A statement there is a low probability of documentation to show the reliability of interruption of the natural Natural gas from our supplier d. A brief description that supports the statement I. Actions taken for the residents regarding the low identified: probability of interruption; e. The signature of technical personnel from the natural gas vendor. #1. There were no specific residents This deficient practice could affect all residents, Identified on the 2567 to be staff and visitors. Effected Findings include: Based on observation on 02/15/11 at 11:00 a.m. during a tour of the facility with the Maintenance Supervisor, the emergency generator was II. How other residents were powered with natural gas only. This was identified: acknowledged by the Maintenance Supervisor at the time of observation. During an interview at 12:05 p.m., the Administrator indicated the facility

gas supply.

did not have a letter from their natural gas

provider as evidence of reliability of their natural

#2. No other residents were identified

As being effected.

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILD	DING 01		(X3) DATE SURVEY COMPLETED	
		1	55275	B. WING		02/	15/2011	
	WATERS OF PRINCETON, THE STREET ADDRESS, CITY, STATE, ZIP 1020 WEST VINE STREET PRINCETON, IN 47670			02/15/2011 CODE				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTION SHOULD BE COMPLETION DATE		
K 144	Continued From pa	ge 4		K 14	III. Systems in pla	ıce:		
					#3. The facility ha Letter from our Provider, showi Of reliability of Gas supp	natural gas ing evidence our natural		
					IV. How the actions v	vill be monito	red	
					#4. CEO/Designee value of The gas letters real To remain in company And be reviewed Quarterly QA m	liability pliance I at the		
	· · · · · · · · · · · · · · · · · · ·							
					V. Date of complete This plan of correct credible allegation all regulatory requirements 2-2	tion constitutes of compliance rements. Our	with	